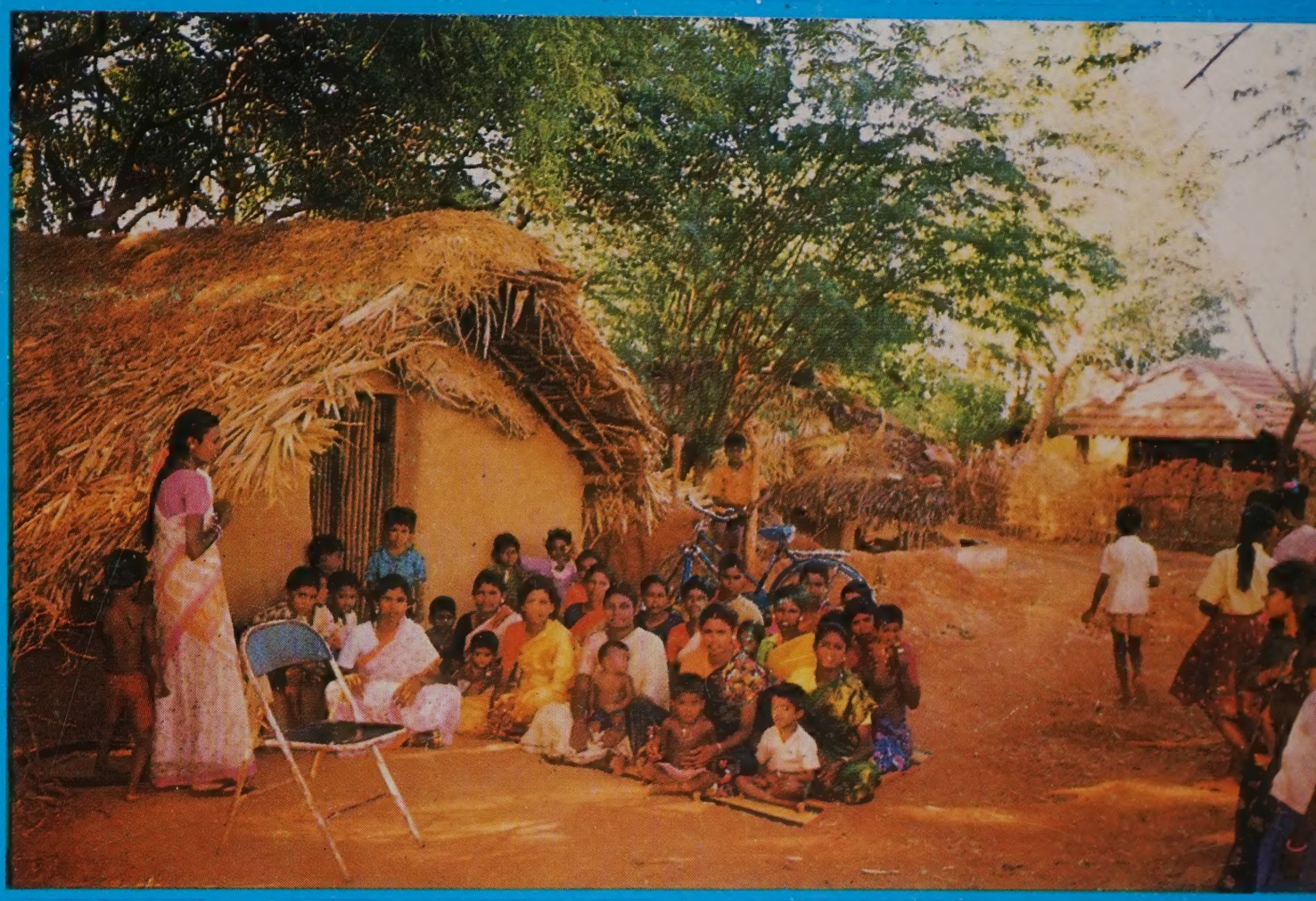
C.S.I. COUNCIL
FOR HEALING MINISTRY

"TOWARDS BUILDING COMMUNITY'S OWN CAPABILITIES IN HEALTH AND DEVELOPMENT IN THE RURAL CONTEXT"



THE COMMUNITY HEALTH GUIDE

WITH A GROUP OF RURAL WOMEN

ALAKUDI VILLAGE

TRICHY – TANJORE

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CHC, Blore

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CSI COUNCIL FOR HEALING MINISTRY

TOWARDS BUILDING COMMUNITY'S OWN CAPABILITY IN HEALTH & DEVELOPMENT IN THE RURAL CONTEXT

BACKGROUND:

One often hears, fears and doubts expressed about the future of church-related health care efforts in this country. Though disconcertin g, this to a large extent, seems to be justifiable. The church leaders often express shock and surprise when it is revealed that more than 60% of the mission hospitals have been closed down in the post-independence era in this country. Scores of our institutions are languishing and it is only logical to presume that several of those may cease to function in the not-so-distant future unless appropriate remedial measures are instituted. One is struck by the apathy and lack of concern of the part of the powers that be, in the face of such a foreboding. The professionals too are not exempt from adopting a lackadaisical attitude. It is timely and appropriate therefore, that we at this forum look searchingly, and critically at the entire scenario in an effort to identify factors that have largely contributed to such a turn of events.

It is useful at this juncture to have a peep into the history of health care efforts in this country undertaken on behalf of the Church. It immediately becomes apparent that the local church did not have an active involvement in the process of planning and organisation of services under the Healing Ministry. Over the years, the major thrust was to build up institutional bases wherever possible and this meant establishment of hospitals small or big, depending on the financial position, as well as the set-priorities of the missionary societies that supported them. Invariably, the local church was at the receiving end and quite comfortably so. The services generated through the church-related medical work were seen by the local congregations as part of a legacy handed down to the local Christian community under a paternalistic dispensation. Needless to say, that they had no role in the planning of programmes and services including identification of resources for making these possible. Neither were they

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interested in taking responsibility in such matters. They fell an easy pray to the temptation of considering themselves as the 'privileged' ones, destined to receive services of a better kind from the benefactors either free or heavily subsidised.

The change-over was too sudden. What happened to our mission medical work during the past two or three decades is only recent history. Very soon, as a matter of policy, Missionaries from abroad were withdrawn, and this included teams of competent doctors and other professionals who were running our hospitals and related institutions. The diminishing flow of resource-support from the foreign missionary agencies came as a blow, too sudden, which several of our institutions could not withstand. Under the circumstances, local churches were neither prepared nor willing to assume responsibility for them. In many instances they themselves were facing the same threat. Regarding the local professional counterparts, atleast to several of them, offering leadership at this juncture, appeared to be too risky. More often than not they silently withdrew from the scene looking for greener pastures.

A NEW AWAKENING:

It is gratifying that the story of the pioneering medical work in India under the auspices of the Church spearheaded by missionary societies does not end there, on that dismal note. Significant developments were taking place the world over, during this crucial period which actually marks a water shed in the political history of a good majority of the countries of the Third World in their struggle for freedom. The socio-political awareness that was generated helped in a large way, to create deeper insight into the very concept of health as well as its socio-cultural determinents.. 'Health' began to be recognised as a human 'right'.

Thanks to the effort of committed community health workers, administrators and social scientists, the problem relating to the huge burden of preventable morbidity and mortality in the developing world, particularly among the rural masses were brought to focus. It was convincingly proved that the

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traditional, hospital based individual patient-oriented approach will neither be effective nor desirable to contain this. The problems at hand required a different set of answers. This realisation paved the way for a series of well-meaning community experiments by dedicated individuals and institutions by dedicated individuals and institutions and led to the emergence of 'alternate strategies' in health care with primary focus on the community. The evoluation of the concept and practice of primary health care, was another unique event in sequence. And, with that a laudable global target has been laid to make 'health care for all' a reality by the turn of the century. Here, the active involvement of the local community in the planning and organisation of services, utilising maximally the local resources including available manpower, marks a major departure as compared to traditional approaches. The adoption of appropriate technology is yet another redeeming feature.

It was evident that this was the greatest challenge facing the health planner and administrator both in the government as well as in the voluntary sector. Also it became amply clear that without the active involvement and support of non-governmental agencies, the national programme goals could never be realised. In the wake of this realisation, the challenge that faced the Healing Ministry was unprecedented, namely making available essential health care to the marginalised rural communities particularly the socially disadvantaged ones, was the need of the hour. This would certainly make a great demand on the church and the local congregations and it is imperative that their potentials have to be fully tapped for the purpose.

The over-view brought out certain inherent weaknesses within the extant system (church-run health care ministry). These are:

- The medical mission functioning as though in isolation and not as an integral part of the main stream of the mission of the Church.

- The apparent non-involvement of the local church and congregation to the Healing Ministry except as passive recipients of services.

- The role of the 'Healing Congregation' not recognised.

- The local congregations had virtually no role in supporting and sustaining the medical mission's effort.

- The Ministry of Healing seen almost an exclusive responsibility of the professionals and the activities generally limited to the precincts of established institutions and to measures aiming at the treatment and prevention of diseases.

- The community health care responsibilities not recognised as falling within the ambit of the Healing Ministry.

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- The Healing Ministry not duly perceived as part of Jesus's Ministry to proclaim the Good News of the Kingdom of God and therefore a vital part of the Ministry of the Church.

THE QUEST FOR ALTERNATIVES:

The foremost task ahead of the Council was to help create an awareness within the Church about the uniqueness of the Healing Ministry and how it is vital to the life and mission of the Church. It was important to recognise the role of the congregation in this Ministry with its focus on 'healing, health and wholeness', imbibing the spirit of the early Church. It was duly recognised that the Church had an inalienable responsibility to prepare the way for making available essential health care to the poor and the needy and those socially disadvantaged communities which have all along been denied even elementary health care and basic social amenities. The Church must exercise a preferential option to reach out and assist such communities, especially in the remote rural areas. Such initiatives should encourage and enable people to exercise collectively their responsibilities to maintain their health and to demand health as their 'right'.

The organisational frame of the Church was viewed as most ideally suited to promote 'primary health care'. It was thought feasible to create a nucleus of essential health care expertise - atleast at a minimum acceptable level - even within the remotely placed rural congregation. This was primarily an effort in building health awareness, and deemed as part of the overall mission of the Church. It was evident that the huge burden of morbidity and mortality, especially among the vulnerable groups, eg. the under-fives, was largely preventable through simple measures of intervention. It is well accepted that a virtual revolution in child-survival and development is possible through such means. It is incumbent therefore on the Healing Ministry of the Church to identify ways and means as to how best this can be achieved. The success of the programme will ultimately depend on how we build community capabilities in health and development.

RECENT DEVELOPMENTS
FROM 'PRECEPT TO PRACTICE'

The CSI Healing Ministry initiating measures towards 'building Community Capability in Health and Development in the Rural Context' stemmed out of the experience gained in India as well as in other developing countries, that the ultimate responsibility for maintaining health status of individuals and of the community rests to large extent on the community itself. However, under such a dispensation, the individual does have a responsibility to safeguard and promote his health. The principle is that ultimately, health care should become a community function and to a large extent attainable through the strengthening of the social support system that is available in a given community setting. We were convinced that a good

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majority of health problems commonly met with at the village setting can be effectively tackled by health volunteers who are drawn from the same community and have been given appropriate training in basic health care. The local congregation can and should take up such a responsibility in response to the mandate to bring 'healing, health and wholeness' a reality in the lives of people. There was an imperative need to visualise and understand the biblical/theological compulsions as to why the local congregations had to be involved in this effort.

The Council is grateful to EZE for making adequate financial support so that the services of a senior pastor with the required special training in 'Counselling and Mission of the Church' was on a full-time basis could be made available to the Council (for a period of 3 years).

The Council conducted a planned series of diocesan level seminars/workshops with this end in view. Awareness building programmes similarly were conducted regionally and even at the congregational level for the purpose so that the message could percolate down to even the peripheral rural church congregations.

All these efforts paved the way for an action-programme with focus on the local congregations towards building community's own capability utilising the services of the 'Community Health Guides'. The Project No.86096 took a turn in this direction. As we look back, the initial 3 years of that project could now be seen as the 'preparatory or pre-planning' phase of the on-going project.

THE PROCESS OF IMPLEMENTATION:

PHASES - 'Preparation of training programmes/curriculam for CHGs and trainers':

There was need for evolving a suitable training curriculum for the CHGs at the diocesan level. It was felt that it was equally important to prepare and equip 'trainers' within the diocese to undertake the responsibility of training of the CHGs. The Council organised a major workshop for the purpose involving resource persons with fund of experience in the field drawn from the medical colleges, health services and voluntary health agencies including those available within CSI (8th & 9th December 1989, at Kottayam). The group subjected to critical review the various training programmes for village health guides available in the country and elsewhere, and drew up a training curriculum, taking into account the socio-cultural singularities in the various regions (the four language regions). Similarly, the groups worked out a feasible training programme suitable for the trainers.

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The next sequential step was to identify co-ordinators within the dioceses as well as those who could serve as members of the trainer/facilitator team, in that setting.

PLANNING WORKSHOPS:

A series of planning workshops mainly to evolve implementation strategies and detailed operational plans were held in this connection . The following deserves special mention - Consultation held at ICSA to work out operational details on 23rd Jan 1991. Consultation organised at Madurai to finalise the plan of operation including the 'trainers training programme' with representatives from all the Dioceses.

The training curricula evolved, were further subjected to review by a core group of senior health professionals, senior pastors, subject-experts and health trainers in a workshop setting, in Madras (ICSA 18th & 19th March 1991 at Madras). It came out clearly that the CHGs training should not be seen as a one-time effort and that each diocese should be able to identify a trainer/facilitator team which would undertake responsibility of 'building competences and skills of the health guides, as situations demand. It was also brought that the training of CHGs should be visualised as an on-going continuous process and that success of the programme would largely depend on the links the CHG is able to establish with the existing health care network, both of the voluntary and government sectors. The Council assisted the dioceses in the choice and selection of CHGs by identifying some useful guidelines and criteria.

The Council organised a training workshop for the co-ordinators and members of the trainer-facilitator teams from our dioceses - 4th to 6th April 1991 at Vishranthi Nilayam, Bangalore. Resource persons were drawn from major health training institutions like RUHSA and CHAD (CMC Vellore), Community Health Cell, Bangalore etc.

The Diocesan representatives were requested to select 10 volunteers (preferably from remotely placed rural congregations) with concurrence of the diocesan leadership. The response from the dioceses were found to be extremely satisfying. The programme has been implemented in the 20 CSI Dioceses in South India. Details showing programme implementation are presented:

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ADMINISTRATIVE PATTERN

CENTRAL TEAM:	Director, CSI - CHM Consultant Engineer Social Scientist
*REGIONAL TEAM:	4 Regional Co-ordinators (Andhra, Karnataka, Kerala Tamilnadu)
DIOCESAN TEAM: (CORE TEAM)	Diocesan Co-ordinator, Training-facilitator team (Medical/Nursing /pastoral care

10 COMMUNITY HEALTH GUIDES
(working in partnership with local congregations)

This programme may be seen as an effort on the part of the church/local congregation addressing itself to the health care needs of rural communities from a wholistic perspective. The programme is unique not only in terms of content of care, responding to the wide spectrum of needs, but also in coverage extending to twenty CSI Dioceses in the four southern states of India. There are over 200 Community Health Guides today and it may be a realistic estimate that atleast 2 lakhs among the rural poor are currently under active surveillance.

* not yet implemented

CURRICULAM CONTENT OF TRAINERS' TRAINING

	TOPIC		Hours
1.	Introduction and concept of the programme	..	2
2.	Communication	..	2
3.	Community diagnosis and management	..	2
4.	Community organisation	..	2
5.	Role of local leaders	..	1
6.	Appraisal of local resources	..	1
7.	Components of primary health care	..	2
8.	Role of health guides in national health programmes relevant to local needs	..	6
9.	Importance of registration of vital events monitoring and evaluation	..	2
10.	Problem solving exercises solving local problems with local resources	..	6
11.	Study of the curriculam given discussion of methodology and suggestion of modifications	..	6
12.	Pre and post-evaluation	..	2
13.	Inauguration and valedictory function	..	2

DURATION - 36 hours, 6 hours /day x 6 days

METHODOLOGY:

Didactic lectures to be minimised group discussions, panel discussions, workshops etc are suggested.

CURRICULAM FOR TRAINEES (VHG)
(DURATION - 1 MONTH (200 HRS)

	Topics	No. of session	Class room	Practical/ field work	Total
UNIT - I	Introduction Primary health care	1	1		
	VHG scheme	1	1	--	2
UNIT - II	Know your community structure	1	1	--	1
	Health & other problem	1	1	3	4
	Felt needs & aspiration of people	1	1	--	1
	Mobilisation of resources	1	1	--	1
	Identification of Leader	1	1	--	1
	Income generating activities	1	1	--	1
	Community health work	1	1	6	7
	Problem solving exercise	1	1	6	7
UNIT - III	Communication Methods	1	1	--	1
	Barriers	1	1	--	1
	How to organise & conduct a group discussion	1	1	6	7
UNIT - IV	Structure & Function of Body General	1	1	--	1
	D. System	1	1	--	1
	R. System				
	C. System N. System	1	1	--	1
	Ex. System Sense organs	1	1	3	4

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	Topics	No. of session	Class room	Practical/ field work	Total
UNIT - V	Communicable diseases (- ref to national programme)				
	Health & disease transmission	1	1	--	1
	Malaria	2	2	4	6
	Filariases	1	1	2	3
	TB	1	1	2	3
	Leprosy	1	1	2	3
	Diarrhoeal diseases	1	1	3	4
	Acute Resp. infections	1	1	2	3
	Sextually transmitted diseases	1	1	2	3
	Others	1	1	2	3
UNIT - VI	Environmental sanitation including water supply chlorination	2	2	6	8
	Solid waste disposal manure pit , composting incineration/burning	1	1	5	6
	Liquid waste disposal soakage pit	1	1	5	6
	Excrcta waste disposal sanitary latrine	1	1	5	6
	Home sanitation, food hygienw Smokless chula	1	1	5	6
	Personal hygiene addictive habits	2	2	6	8
UNIT-VII	Nutrition Common food, nutrients importance, need	1	1	--	1
	Preparation, supplementation	1	1	--	1
	Deficiency - undernutrition grades of malnutrition, iron deficiency Vit - A	1	1	--	1
	Kitchen garden - nutritional programmes & ICDS	1	1	--	1

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Topics		No. of session	Class room	Practical/ Field work	Total
UNIT - VIII	MCH & FW Mother care	1	1	3	4
	Danger signals in pregnancy and post-natal period	2	2	6	8
	Child care - neonatal care, breast feeding, immunisation family planning	2	2	6	8
UNIT - IX	Vital events records, its need & importance	2	2	--	2
UNIT - X	First Aid , dog bite, snake bite, drowning, burns, fall and fracture, shock, bleeding foreign body	4	4	18	22
UNIT - XI	Basic nursing service (Nursing care, rehabilitation), treatment of minor ailments, fever, cold, cough, headache, bodyache, joint pains, myalgia	2	2	3	5
	Scabies, ring worm, boils ulcers, sore eyes	1	1	6	7
	Worm infestation	1	1	3	4
UNIT - XII	Mental Health, detection and follow-up	1	1	--	1

METHODOLOGY:

Lecture - minimum
Demonstration - class room/clinic/field
Group discussion
Role play
Simulated exercises

HEALTH CARE INITIATIVES OF RURAL CONGREGATIONS - THE VISION & THE MISSION

THE STORY OF A UNIQUE EXPERIENCE

Kathiruppu is one among those 'sleepy' villages in Tamilnadu located in the Eastern Coastal belt bordering the rich and prosperous Cauvery basin. For the people of this village and for many others living in the nearby villages, it is as though time has stood still for decades together. This is only to be expected as the developmental efforts during the past have hardly made any significant impact on the lives of these poor people.

The Cauvery deltaic region around Tanjore is reknowned for its high agricultural productivity, and proudly referred to as the granary and 'rice bowl' of Tamilnadu. The region is equally remembered for its great contributions to the cultural heritage of the country particularly in the field of Carnatic music. It remains a paradox, however, that scores of villages in an extensive land tract bordering this region are known for its age-old backwardness and where extreme poverty is prevalant due to low productivity mainly attributable to adverse weather and soil conditions. The sea port of Tranquebar, the oldest dutch settlement on the eastern coast is only 30 kms away, notably this town is remembered as the cradle of Christian Missionary Movement in India, initiated by pioneers like Ziegenbalg and his co-workers. In Kathiruppu there still exists the remains of an ancient Dutch built church, where the core structure is maintained and used as the place of worship by the local CSI congregation even today.

Good majority of the villagers living in Kathirappu and the cluster of hamlets all around belong to the socially disadvantaged communities. People are poor, their standard of living is deplorably low. There is a church run primary school in the neighbouring village. The average literacy rate is low as compared to other regions. The nearest primary health centre is about 10 kms away. The impact of primary health centre on the rural community is only notional.

This was the village setting where Juliet Margaret, a twenty year old youngster returned to work, after completing her training as a Community Health Guide. An active member of the local CSI Church, and quite popular with the young children as a Sunday School teacher, she was chosen by the congregation for undergoing the CHG training, which was organised by the CSI Trichy-Tanjore Diocese. It was a four-week long residential training programme and there were nine others along with her representing different areas within the Diocese. Margaret had done her schooling up to X std. She had never before stayed away from home, but her parents, the pastor and the local church leaders encouraged her, and gave the support and backing that she needed so badly at that time to take up the challenge.

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The four weeks she spent in Trichy proved to be a momentous period in her life! For the first time she came to know that even as a lay person with her limited educational background and experience, she could play a crucial role in the Healing Ministry of the Church, serving the poor people, among whom she lived. Her understanding of the gospel was strengthened and reinforced that 'whatever little she could do by way of service to the poorest and the neglected, would be considered by Jesus as service rendered to Him'. Rev. Joseph Samuel the Pastoral Co-ordinator, who conducted devotional studies regularly helped to create deeper insight into the wholistic approach to the ministry. The aim, he explained was to help bring about 'healing, health and wholeness' a reality in the lives of people, taking lessons from our Lord's own ministry. It was a ministry tending to the needs of the whole person, spirit,soul and body and she was called upon to emulate that model through her own work and witness.

She learned about the common health problems of village communities, and the pattern of diseases prevalent among them. There was focus on the special needs of infants and young children, and also of women during pregnancy and of mothers who had to nurse their babies. She learned that by following simple, yet basic principles of health and hygiene, a large majority of common diseases prevalent today in the community could be prevented, also the importance of simple and timely interventions to avoid complications and even death. There was a great and urgent need however to create awareness among the women in the villages she know so well, about ways and means of safeguarding health of members of their families especially that of young children. They learned a good deal about the nutritional needs of the growing child the need for monitoring of their growth and development and also about their common illnesses and how these could be effectively handled by simple medical measures: but this message had to be effectively passed on to the rural mothers and that was a critical responsibility indeed! She know that if she could build a good and healthy relationship with the PHC workers, the much-needed primary health care services could at long last reach the rural homes. The resources were there but these have not been availed by the poor rural families. Her mind was set and her doubts were cleared; she had a lot of things to accomplish in the days to come when she returned to her village.

It was indeed a revelation, that as a member of the local church congregation she too was called to be part of the healing community and that the unique privilege was her's to be a co-worker with Jesus. On the closing day, it was announced that very soon the Diocese was going to 'commission' them in that 'role' during a formal ceremony of thanks giving. It has been decided that the Bishop of the Diocese was going to dedicate and bless them for the ministry.

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It was a day of great rejoicing for the people of Athannur village (25 kms away from the nearest town Pattukkottai) as they had the privilege of hosting a unique diocesan function. The Bishop of the Diocese was visiting them in that connection. They were to offer a ceremonial welcome befitting the village traditions! A large platform was erected in the mission compound. The Village road leading to the mission compound was tastefully decorated with festoons and bunting. Hymns of praises filled the air befitting the solemn occasion. It was a open air worship service and at the appointed hour the CHGs were invited to come forward and each one kneeled on the platform. The Bishop then laid his hands on each of them invoking God's blessing as they were being inducted to serve in the ministry.

To Juliet, the day she returned to Kathirippu, marked a turning point in her life. She know about the tasks and responsiblities ahead of her. She was equally conscious of her limitations. Juliet remembered too well, the oft quoted proverb which Jesus Himself referred to, that a prophet is never welcomed in his home town! But that did not deter her at all. She had set her goals and that in response to an inner call to help and assist the poor and innocent people of the area with whom she had so much in common and to whom she owed so much.

First of all, she recognised that she needed the support of the local church and of the local community. Juliet met the pastor and the leaders of the congregation together on several occasions and shared with them the highlights of what she had learned and about the vast and varied opportunities that lay ahead of them, to help build healthier communities through planned efforts, and working together.

She started moving among the villages. Many of them knew her well but she had to establish contact with several others. While her initial point of contact was the woman of the household, she soon discovered that there were many children as well as girls of her age who were deeply interested in the type of work she had been planning for and were most happy and willing to move round with her to assist her at every stage.This was a discovery indeed and greatly encouraging. She could bring together a band of children and youth to prepare and equip them to offer 'leadership' in activities that were to be initiated in the local villages.

The informally conducted initial survey revealed to her that the village community had hardly understood the nature and extent of their health care needs. Early indications and symptoms of ill health and disease were hardly taken note of till overt sickness over took them, forcing them to keep away from daily chores, mainly working in the farms, or on casual labour.

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Malnutrition was rampant especially among the young children. She could discover signs of a wide range of deficiencies of vitamins in a large majority of young children. Generally, they were thin and emaciated. Their eyes were lustreless and browning and wrinkling were seen almost in every child. Fissuring of the angles of the mouth, 'Myna lips' (colloquial term for angular stomatitis) was common indeed and that irrespective of age.

A closer search revealed that a large majority of the under-fives, in several of the hamlets, were never protected by immunisation against the six potential killer and or disabling diseases (TB, diphtheria, tetanus, whooping cough, polio, measles). The community had failed to take advantage of the 'universal immunisation programme'. Several mothers confessed that they did not know about the importance of repeating the doses at an appointed time interval, to 'complete' the course of immunisation to give adequate protection to their children against these diseases.

She realised that the Heath Centre team members visits to these distant villages were very infrequent and casual. The villagers therefore never took them seriously! Many mothers told her that the health workers however would stream in for aggressive canvassing during family planning camps held occasionally in the local health centre or in the District Hospital.

Juliet planned her agenda. She succeeded in bringing together groups of young people which included children attending the Sunday School and the youth fellowship. She proved to be quite successful in preparing local teams to move and work among the village homes in the area, and even the neighbouring hamlets mainly collecting vital information and helping in creating health awareness. She taught the children meaningful songs and hymns carrying core health messages, stressing the need for collective efforts. Popular folk media like *'Kolattom', 'Kummi', and 'Vilpattu' were employed effectively for the purpose. She had composed a few songs herself. Skits and street plays were also used with advantage. Children were happy to play their roles in all these efforts and the parents were proud of the talents their children displayed.

Commmunity leaders were impressed with the new wave of enthusiasm that was being created, thanks to the collective efforts of Juliet and the young team she prepared. There were visible signs of a new awakening within the whole community. The young local team had won the love and admiration of the village community irrespective of considerations of caste or religion. The village leadership was convinced for once, that their achievements and strength ultimately depended very much as to how best they could 'build their own capabilities' in health and development. They had 'resources' within which however had to be 'identified' and 'mobilised', in fact the potentials within each community had to be fully utilised.

The leaders among village congregations men and women met and discussed issues and problems, thanks to Juliet's initiative. The pastor and the local leaders stood by and offered support to the programme they all jointly drew up, on the basis of priorities that were identified.

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A few months had elapsed. At the instance of Rev. Joseph Samuel, Co-ordinator, the core-team of the Synod Council for Healing Ministry had the privilege of visiting Kathiruppu village, and meeting the local congregation. A special get together was being organised. The old church was full. Children from even the neighbouring hamlets had assembled. This was indeed a programme with a difference! To all of us, it was more a demonstration of what our children and youth could achieve and contribute once they were sure of the goals ahead, organised themselves, given the required leadership training and the freedom to work.

Kathiruppu was no more the sleepy village that it once was, where time stood still for decades! It was now a time of display of talents; festivity was in the air! The compound around the ancient church was cleaned up and decorated. Elaborate floral designs were made on the ground levelled and rammed for the purpose. to welcome the visitors in the traditional way. The ancient Church building itself had received a face-lift.

The occasion marked the finale of hard work on the part of Juliet and her young team, of several weeks of house to house compaigning and organisational efforts towards creating an awakening among the local community - much had been achieved in a short span of time. People who had gathered, represented several nearby villages and rural congregations. For all of them it was a time of fellowship and sharing of experiences, in fact taking stock of things that had happened to them in the recent months. Let us listen to Juliet:

Pointing to the crowd of children in front of her and many of the little ones accompanied by their mothers, she affirmed with a sense of fulfilment that all of them had been fully covered by immunisation, making use of the Health Centre facilities. She and her local team of friends had only to perform the enabler - facilitator role for achieving this. Their job was more of an effort towards creating awareness about the 'need' among the local communities and at the same time, building healthy links with the peripheral health team of the PHCs.

There were kitchen gardens coming up in the backyards of many rural homes. This was a commendable effort towards improving general nutritional status of the community, with their own efforts. Children could recite poems and sing songs conveying crucially important health messages covering a variety of areas, the focus was on 'healthy life styles'. Children demonstrated the skillful use of different folk media that had become popular in community health education programames. It was observed in fact, every child present there could repeat these rhymes - the message had been conveyed and well received.

Notable among those who spoke on the occasion were the pastor, the headmaster of the primary school and the elders of the Church and of the local community. They all hailed the efforts of the local team under the leadership of Juliet and expressed their confidence in them. All the same, they all expressed their concern

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about the variety of health needs that have surfaced and have to be met. They were conscious of the fact that there were no health care facilities any where near, to meet even 'emergencies' that were so common. It was revealed that snake bites and scorpion bites were rampant and still rank high as a cause of death of children and of adults! The senior pastor from Nangur duly endorsed this sad reckoning and said that for emergencies of any kind, including episodes of acute illness and accidents, the village community from all around would first come to him seeking his advice and help. Evidently his position was most unenviable! Something had to be done, the church and the local congregations could not be silent spectators any longer. The time was ripe and now to respond positively It was a solemn resolve to move forward - the pastors and the local leaders decided to work out a feasible plan of action.

Within a short span of three months, the core-team of the Council received an invitation from the Pastoral Co-ordinator to visit the area once again as a 'Rural Health Centre' was going to be dedicated by the Bishop of the Diocese Rt.Rev.Dr.R. Paulraj in Nangur Village. This was an answer to prayer, certainly a venture of faith, a near miracle! How did they organise themselves? How did they find the resources?

The Nangur parsonage is located in an extensive compound in the midst of a coconut grove planted by the early missionaries. The mission bungalow located there is nearly a couple of centuries old and was breaking down, and discarded for several years. Extensive repairs of this building was recently taken up by the diocese and once again made habitable and rededicated for use as the 'parsonage'. At the far end of the compound there were the remains of an ancient church building which was abandoned. Leaders of the congregation, after several meetings and consultations took the bold decision to convert this building into a 'health centre'. The decision was to retain the stable part of the remaining structure, to get it repaired and put to use. The work was completed in record time. The country tiles and supporting wood work were replaced, the walls and the floor replastered. A historic church building, used for worship services by generations was now to be restored and put to use as a centre where many would receive the blessing of healing! The long felt need for a health centre for the rural community was being met.

Juliet and her colleagues were excited, they were busy on the job once again getting the compound cleaned up and decorated, floral designs, festoons all over again. One could hear even from a long distance, songs of praise, wafting the gentle air. It was a festival for the entire community. For them it was a great and significant moment in that a dream of generations to have a health care facility in the vicinity was being actualised. Thanks to a process, that was set in motion to create an awareness among the local communities about

..7/-

The local congregation had a significant contribution to make in creating a wider understanding about human needs from a wholistic perspective. The Believer's primary role was to be 'agents of change' to help bring about healing and health to individuals families and to communities. The experience gained brings into sharper focus the potentials and resources that are available in every rural community that has to be mobilised for common good. It has a lesson for all those concerned about the development of people that the yardstick for measuring the success of their efforts should be, as to how far the approach and measures employed help to build communities own capabilities especially in the context of health as well as development.

In the case of this village the people have started their sojourn, an impressive start indeed, but they have a long way to go! The story has brought us only to the end of that beginning!

(DR. GEORGE JOSEPH)

* **KOLATTAM:** Action song and dance usually performed by girls. Each carry a pair or short sticks and the rhythmic noise produced by striking the sticks help in building up the pace, and tempo of the dance.

KUMMI: A graceful group dance of women popular in Tamilnadu - almost the same as Kolattam but dance is accompanied by clapping of hands and usually the group moves back and forth in circle.

VILLUPATTU: The popular folk media for story telling and entertainment where a small group of participants wearing special costumes and heavy make up squat on the floor! There is a leader who introduces the theme and follows it up with appropriate song and dialogue sequences.

There is a large bow, kept in the middle often made for the occasion, with a thick string tied accross the ends and row of bells hanging on it. One end of it is fixed to a large mud pot to enhance the resonance.

matters related to their health and that as a crucial determinant of their overall development. This was indeed a new understanding. As has been the experience of others like her, she was initiating a process, in fact setting in motion a 'chain reaction'. Certainly, creating awareness about the need was the first step. There are other steps to follow in sequence. It is well known that the awareness soon becomes a 'concern' and an 'expectation'. This later becomes a 'demand'. Her hard and consistent efforts hastened this process. The community not only came out with a demand for a health facility, but have identified and mobilised resources from within seeking and ensuring assistance from all quarters to meet the demand. This was made possible, because the critical level of awareness in the community was reached through an enabling process thanks to the well directed efforts of Juliet and her team of young friends representing the sunday school, the youth and the mother's group.

Let us watch the development a little closer: The community felt the need for having a multipurpose health worker who would stay in the village itself and would help provide essential services as and when needed. The community was willing to provide residential facilities for such a health worker.

Due publicity was given, and the local church leaders were able to identify a suitable candidate duly trained to handle the responsibilities in the new health centre. As part of the dedication ceremony the health worker was introduced to the local congregation. Her major function would include community organisation health education with focus on health promotion and maintenance of health and early detection of ill health especially among the vulnerable groups, she will provide direct services within her competence. The Health Worker and the CHG formsthe"core team'for complementing each other according to their background and competence.

CONCLUSION:

This is the story of rural community traditionally poor and backward, now passing through a crucial state of rapid development transition. As the story unfolds itself, one comes face to face with grim realities, the characters who are introduced to us have something to share with us. They do not however speak: they are the faceless, the silent minority in India.

As we take a walk along with them we really get aquainted with the depth of their misery and understand their despair. More than the poverty, it is the alienation from the main stream of life and the stigma that the socially disadvantaged communities still suffer from, that catches the discerning eye.

Now regarding the process that have helped to the rapid transition: firstly, thanks to the effort of Juliet and her team who were part of the very community, the people were made conscious of the several factors operating both within and externally, that were blocking their progress and development all along. The Community Health Guide also helped to create the critical awareness among the community not only about the wide spectrum of health care needs but also to recognise 'essential health services' as their right.

..8/-

DORNAKAL:

Dornakal Diocese is mainly a rural Diocese with 550 congregations spread out in 5 Districts, namely, Khammam, Nalgonda East Godavari, West Godavari and Koraput (Orissa State). A significant proportion of the total population are tribal. Primary Health Care services both in terms of content and coverage in many villages leave much to be desired. The Diocese has 2 hospitals, one at Dornakal and the other at Khammam. A multi purpose training schools is attached to the Khammam hospital. The Diocese also has an innovative programme for rehabilitation of children who are polio affected employing the transit home concept successfully. It is a sad reckoning that rural health care does not attract health professionals including doctors. This brings out clearly the need for evolving alternate strategies to make essential health care available to people. The scope and relevance of Community Health Guides is evident. A beginning has been made to involve the youth fellowships of local congregations especially in remotely placed villages to promote community level preventive health care programmes (immunisation coverage of rural children) and nutrition education. The programme needs to be revitalised using the service of the nurse-trainees as part of their field programmes.

"Let us remember that two-thirds of the world's people are under-privileged - under-fed, under-healthy, under-educated - and that many millions live in squalor and suffering. They have little to be thankful for save hope tht they will be helped to escape from this misery ... these (problems) are all symptoms of a new evolutionary situation; amd this can only be successfully met in the light and with the aid of a new organisation of thought and belief, a new dominent pattern of ideas relevant to the new situation".

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : DORNAKAL

Bishop : Rt.Rev.D.Noah Samuel, B.D.

Diocesan Coordinator : Rev.D. Jermaiah

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilita team & place of training.
T.Nalini Devi	Thulasi Pakalu	Rev.Jermaiah	Mrs.Chinthamani Devaram
M.Esther	Rallagudem	Rev.Jermaiah	
K.Krupa	Mamidigudem	Rev.K.John Rajan	Rev.Th.Yesudoss
S.Rojavani	Uppalamadaka	Rev.K.John Rajan	Mr.M.Yesudoss
M.Metilda	Naguballi	Rev.G.John	Rev.K.Yesupadam
K.Mary Jujatha	Lakkavarun	Rev.K.Nagarathnam	Mr.Augustine Bunya
P.Mary	Nidanapuram	Rev.B.Ch.Babu Rao	Rev.K.Padma Rao
K.Suvarchala	Kothalingala	Rev.B.Ch.Babu Rao	E.R.M.Hospital Karimnagar, 2 - 11 Dec.'92 & 11-24 Jan. '93
Ch.Dayamani	Suryathanda	Rev.T.John Jawahar	
D.Pramoda	Injaram	Rev.Y.Vedarathnam	

KARIMNAGAR:

A predominantly rural spread out in remote villages falling within Karimnagar and Warangal and part of Nalgonda Districts in Andhra Pradesh, a large portion belongs to 'Telengana' region know for its traditional backwardness. The age-old oppression of the tenants under the feudal system in existence paved the way for people's liberation movement including armed struggle in the naxalite way. Karimnagar also has a significantly large proportion of tribals. Basic facilities including health care have yet to reach the interior villages. The diocese has encouraged alternative systems of medicine - there are two Homeopathic hospitals, the Parkal region.

There is a great need to supplement the existing health system through encouraging local community health care initiatives.

The diocese has 2 hospitals - a general hospital in Karimnagar and a rural hospital at Panigiri which has been revived and there is great scope for village outreach programme, relevant to the setting to be taken up in several outlying areas. Extensive field visits have revealed that the Primary Health Care services under the state, as far as the remotely placed rural communities are concerned are at best notional, pointing to the great need for alternatives.

"Like Jesus, the church ought to give special attention to the nobodies and those without a voice. It should emphasise the future that he promises for this world, a world in which the future kingdom is growing between the wheat and the cockle, not for a few privileged people, but for all".

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **KARIMNAGAR**

Bishop : **Rt.Rev.S.J.Theodore, B.D.,M.Th.**

Diocesan Coordinator : **Rev.K.Wilfred Dinakar.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitato team & place of training.
B.Sudeevena Joseph	Peddapally	Rev.B.Joseph	Sr.Devabala Simon Mrs.Y.Margaret Mrs.C.Padma Rao E.R.M.Hospital Karimnagar. 20-27 Aug.'91 & 26th Oct - 5th Nov '91
B.Swaroopa Rani	Ernapalli	Mr.B.J.Sudhakar(E)	
B.Venkatamma	Kondapuram	Rev.J.Azariah	
E.Swaroopa	Moddulapalli	Rev.B.Joseph	
J.Kanthamma	Mulog	Rev.Ch.SanjeevaRao	
J.Dayavathy	Rekampalli	Mr.B.PrasadaRao(E)	
A.Kamalamma	Lingagiri	Rev.N.Prabasham	
S.Varalaxmi	Pakala	Rev.R.Premanandam	
B.Miriyam	Boddugudem	Rev.J.Azariah	
J.Padma	Mothukur		

KRISHNA-GODAVARI:

Krishna-Godavari is one of the largest dioceses spread out in 6 revenue districts. Barring a few cities and towns the activities of the diocese are mainly confined to rural population which includes a significant proportion of tribals.

The tribal pockets are generally located remotely placed in interior villages. The diocese has done pioneering work among the tribal population in Atlapragada Konduru region. The focus was on 'building community capability in health' to the extent feasible. There is a rural health centre at A. Konduru with resident nurse and auxiliary staff mostly for maternal and child care and also monitoring the work of local dais. There has been a concerted effort to revive the practice of tribal medicine in this community through a process of integration. A major achievement relates to the immunisation coverage of the under-fives of the rural communities under reference utilising the governmental resources maximally and the service of the local health volunteers for youth/W. fellowships.

Besides the Anantham Hospital in Vijayawada, outreach programmes have been initiated, in the peri-urban areas thanks to the efforts of local congregations and that of local schools.

"The sense of earth opening and exploding upwards into God; and the sense of God taking root and finding nourishment downwards into Easth. A personal, transcendent God and an evolving universe no longer forming two hostile centres of attraction but entering into conjunction to riase the human mass on a single tide. Such is the sublime transformation which we may with justice foresee".

(Teilhard de Chardin; Building the Earth, p.75)

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **KRISHNA-GODAVARI.**

Bishop : **Rt.Rev.T.B.D.Prakasa Rao, M.A.,B.D.,B.Ed.**

Diocesan Coordinator : **Rev.P.D.Vijayaraju.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitator team & place of training.
Tere Lilly Florence	Kondapalli	Rev.Powlas Rajkumar	Mr.P.Samuel Mr.S.Banjamin Rev.P.D.Vijayaraju TRCR Arogyavaram 5th Nov. to 25th Nov'92
D.Jayamma	Tsanubanda	Rev.P.Suresh Ravikumar	
P.F.U.Angel	A.Konduru	Rev.Churchill Paul	
A.Pramila Kumari	Tennuru	Rev.M.D.Sathyavarthanarao	
Lam Kumari	Uppuluru	Rev.M.D.Sathyavarthanarao	
P.Vijayamma	Poranki	Rev.Gnana Prakasam.S	
Dandebettini K.Ratnam	Nunna	Rev.John Willson.D	
K.Ratna Kumari	Vidyadharapuram	Mr.P. Samuel	
Kanthipudi Mary	Vidyadharapuram		

MEDAK:

Medak Diocese is a northern most Diocese within CSI bordering Maharashtra. It covers 4 revenue districts all of which form part of the erstwhile princely state of Hyderabad. Barring the twin-cities, the entire region is rural where primary health care efforts have yet to make its impact on the poor rural masses. The Diocese has 4 rural hospitals and a major leprosy hospital as well as a Leprosy Research Centre (Dhoolpet). There is a great need for strengthening the rural institutional network and the outreach programmes.

Plans are well underway for starting the multipurpose workers training programme for the Andhra Region. which will be a major milestone to initiate and or strengthen community health programme in the needy rural areas in the Andhra Dioceses. We are more than convinced about the role of the voluntary sector to supplement/complement the state health care programmes. The potentials of the local congregations have to be fully utilised for the purpose, to facilitate healing, health and wholeness among people which after all is the core mission of the church.

"If India is not to perish, we have to begin with the lowest rung of the ladder. If that was rotten all work done at the top or at the intermediate rungs was bound ultimately to fail"

(Mahatma Gandhi)

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **MEDAK**

Bishop : **Rt.Rev.B.P.Sugandar, B.D.**

Diocesan Coordinator : **Dr.B.S.Frank Israel.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitator team & place of training.
Maria	Linganpalli	Rev.D.Yohan	Mrs.Margaret Padmar
Pramila	Chityal	Rev.Premanandam	Rev.K.Joseph
Asmathabasum	Komatur	Rev.Premanandam	Mrs.S.S.Thilaka Jos
Sidhamma	Maddulvai	Rev.B.Devadass	Rev.B.P.Sugandar
Swarnalatha	Rasapalli	Rev.Premanandam	CSI Hospital, Medak. 25.11.'92 to 4.12.'92
Bharathi	Muthoikota	Rev.B.Devadass	
Yashoda	Bathole	Rev.D.Yohan	
Yesumani	Ralamadugu	Rev.Premanandam	
Yesumani	Venkatapuram	Rev.Premanandam	

NANDYAL:

A predominantly rural Diocese. The area includes a large mountainous terrain which is a tribal belt. The Diocese has 2 hospitals, one located in Nandyal town and the other in Giddalur which is a head village in the tribal zone. The Diocese has laid special emphasis on prevention of blindness programme being made available to the population. Facilities for cataract surgery are provided in Nandyal Hospital. Eye camps are held in the villages for screening of cases and surgical correction done in Nandyal, Giddalur too has a lady doctor trained in ophthalmology and eye care programmes are integrated with primary health care efforts.

Efforts are underway to complete the construction of health centre at Giddalur which hopefully will help bring the benefits of modern medicine to people of these tribal belt, neglected all along. It is worthy of mention that the women's fellowship of the Diocese has played a major role in organising the CHG programme in the Diocese.

Net working and sharing responsibilities among the organisational units within the church itself (W.F. & Y.F.) can lend greater meaning and purpose to such efforts.

If my dream is fulfilled, and every one of the seven lakhs of villages becomes a well-living republic in which there are no illiterates, in which no one is idle for want of work, in which everyone is usefully occupied and has nourishing food, well-ventilated dwellings, and sufficient Khadi for covering the body, and in which all the villagers know and observe the laws of hygiene and sanitation, such a State must have varied and increasing needs, which it must supply unless it would stagnate.

GANDHIJI

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **NANDYAL**

Bishop :

Diocesan Coordinator: **Rev.M.Rajasekhar.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitator team & place of training.
Graceamma	Chapirevula	Rev.P.Abraham	
A.Mary	Jullepalle	Rev.M.Yesudass	Mrs.Veena Bunyan,
Obalamma	Sitarampuram	Rev.P.Abraham	Secretary, W.F.
G.Marthamma	Iyalur	Rev.P.Abraham	
L.Ratna Kumari	Ambavaram	Rev.Raphael	Arogyavaram
N.Saralamma	Jayarampuram	Rev.Raphael	Madnapalle
Rose Mary	Chinnaganipalle	Rev.H.Krupakar Rao	
P.Pushpaleela	J.Pullalchervu	Rev.H.Krupakar Rao	21st Feb '92
Vijaya Ratna Mala	Eramchettiyaripalle	Rev.R.Vijaya Raj	to
Praffula	Bodduvanipalle	Rev.R.Vijaya Raj	3rd March '92
G.Lalithamma	Nandyal (S)		
V.Vasantha Kumari	Giddalur(S)		

RAYALASEEMA:

The diocese is remembered for the pioneering contributions in major fields medicine and of health care. Arogyavaram Medical Centre - the erstwshile Union Mission Tuberculosis Sanitorium, Madanapalle is remembered for it invaluable research contribution,which has led to the National programme for Tuberculosis control in India. The Diocese has another major hospital serving traditionally poor rural areas where extreme degrees of malnutrition are rampant, particularly among the under-fives. Thanks to the concerted research efforts of Dr. William Cutting and his team, feasible measures to combat severe degrees of malnutrition through a package programme of nutrition rehabilitation were evolved with its focus on the family resources, and the role of the mother, community-based nutrition rehabilitation brought answers to this major problem, which has led to a significant reductionof childhood mortality and morbidity arising out of malnutrition.

The establishment of a Training and Research Centre in Rehabilitation at Arogyavaram, marks yet another major landmark. The thrust is on community based rehabilitation.

"Many persons still tend to think of the primary health worker as a temporary second best substitute for the doctor, that it if were financially feasible, the peasantry would be better off with more doctors and fewer primary health workers. I disagree. I have come to realise that the role of the village health worker is not only very distinct from that of the doctor, but, in terms of health and well--being of a given community is far more important". David Werner

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **RAYALASEEMA**

Bishop :

Diocesan Coordinator : **Mrs.Marthamma Margarate.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitator team & place of training.
Marthamma	Badraiahgaripalle-Mudivedu Thamballapalle Mandal.	Rev.Devapriam	Mrs.S.P.Devadatta Mrs.Martha Margarat
Geethamma	Panchalamarri-Harijanwada Thamballapalle Mandal.	Mr.Bharath Bhushan	Rev.K.Shadrack.
Jeevarathnamma	Badikayalapalle-Burakayalakota Mandal.	Rev.B.Prabhakar	Arogyavaram, Madnapalle 17.6.'91 to 23.6.'91
Sundramma	Laddigum-Punganur Mandal.	Rev.Y.D.Raphael	Jammalamadugu 5.8.'91 to 14.8.'91
Gokula Elshamma		Rev.Devadanam	
Panditi Jayamma	Sugumanchipalle	Rev.Devadanam	
Bothala Prameelamm	Devagudi	Rev.Swaminathan	
Gopaldas Ineekamma	Uppalapadu	Rev.Swaminathan	
Pari Krupavathamma	Moragudi	Rev.Devadanam	
Bellam Suseelamma	Gudemcheruvu Bommepalli.	Rev.Devadanam	

NORTH KERALA:

The Diocese covers over 8 revenue districts. From the point of view of overall development compared to the rest of Kerala, the Northern districts are backward. This applies especially to the population along the coastal belt as well as those in the high ranges. The North Malabar region is known for its religious and cultural diversity. Significantly, a large proportion of the population are Muslims. Under the feudal system which dominated for centuries, the right of ownership of land was restricted to few powerful families leaving the tenants in abject poverty and misery. It is note worthy in North Malabar especially in the mountain ranges and foot-hills, there are several major Adivasi groups with distinctive ethnic identity. The benefits of primary health care of any quality have yet to reach large sectors of rural population in these extensive land tracts.

Working together with greater ecumenical understanding encouraging networking with voluntary agencies can be helpful to find answers to the variety of needs among the people within the various regions.

Plans are under way for reviving the provision of health care facilities in Chombala which will go a long way in providing primary health care to a large section of poorer communities living in the coastal belt. There is need to evolve feasible models of care for the tribal population living in inaccessible pockets. Meppadi Hospital can play a crucial role in this contexts. Karunalayam in a unique institutions for the rehabilitation of hapless ex-leprosy patients. There is great scope for developing this as a centre for caring for the terminally ill/care of the the elder citizens who need institutionalised services.

"Health cannot be forced upon the people. It cannot be dispensed to the people. They must want it and be prepared to do their share and to co-operate fully in whatever health program a country developed. Sigerist

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IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **NORTH KERALA.**

Bishop : **Rt.Rev.Dr.P.G.Kuruvilla**

Diocesan Coordinator: **Mr.Robert S.Srinivasan.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitato team & place of training.
Annamma T.A.	Poomala	Rev.Thomas Abraham	Mrs.Letitia Janar danan, Mr.Robert S.Srini vasan. Shoranur Retreat Centre 21.4.'92 to 11.5.'92
Lissiamma Joseph	Thrissilery	Rev.Dn.Praise Th	
Annamma Samuel	Thrissilery	Rev.Dn.Praise Th	
Kamala Jane	Chombala	Rev.Christy Paul	
Santha John	Vaniamkulam	Rev. Jose peter	
P.Regina	Surianalle	Rev.James William	
Suganthi Selina	Surianalle	Rev.James William	
Aleyamma Ajayan	Vallithode-Iritty	Rev.Babu Varghese	

MADHYA KERALA

The state of Kerala in general and the region covered by the Madhya Kerala Diocese falling within Kottayam and Alleppey districts in particular is considered to be on the fore-front as far as overall development is concerned. Development indices such as literacy rate, especially, women's literacy, low birth rate, low maternal mortality rate and the like are used to prove the point. The figures appear flattering. The interpretation made of such statistical averages often brings about a false sense of achievement leading to complacency, detrimental to development planning itself. The fact remains that a significantly large proportion of the population have no access even to rudimentary health care. Unemployment especially among the educated adds a new dimension, bringing in its wake a variety of issues and social problems, eg. suicide rate/attempted suicide rate per-capita consumption of alcohol are indicators revealing disturbi trend. Due to severe pressure on land, there is migration towards the high ranges braving the inhospitable terrain and weather and scores of small to medium size colonies have sprung up during the last two or three decades.

The diocese also covers a vast area in Kuttanad, where the traditionally poor and socially disadvantaged communities have lived under virtually sub-human living conditions for ages. These are very many small islands, each inhabited by several households spreadout in the backwaters and lagoons in and around Kuttanad. These are veritable 'islands of poverty', squalor and ill-health. Small country boats - 'canoes' serve as the only means of transport. Water borne diseases are still rampant. Responding to hte medical and nursing care needs was seen as a pioneering challenge by early missionaries and a floating dispensary was introduced during the thirtees. There is still scope and relevance for reviving this programme.

For Kerala, a deeper search will uncover a strange mix of problems characteristic of under developed as well as developed economies. This essentially calls for a new approach to planning.

"And the King will answer, "I tell you this: anything you did for one of my brothers here, however humble, you did for me".

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **MADHYA KERALA**

Bishop : **Rt.Rev.Sam Mathew.**

Diocesan Coordinator : **Very Rev.T.C.John.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitat team & place of training.
Annama James	Njaliakuzhy	Rev.P.V.Varghese	Prof.Ninan Thom
Leelamma Philipose	Ranny	Rev. George M. Sathianathan	Very Rev.T.C.Jo
Annamma Mathew	Velloor	Rev.Chacko Varghese	
Aleyamma John	Kunnikadu	Rev.K.J.Mathai	BJSM Hospital Pallom
Mollykotty Joseph	Angadikkal	Rev.Paul Samuel	
Mariamma Verghese	Kardam	Mr.P.D.Mathai	
Santhamma Oommen	Perumthuruthy	Rev.Paul Samuel	11.9.'91 to 11.10.'91
Saramma John	Kothala	Rev.V.J.George	
K.K.Thankamma	504 Colony	Rev.John P.Robinson	

EAST KERALA

The youngest diocese under CSI. Population is mostly confined to Idukki District covering mostly, the population in the high ranges and adjacent areas of Kottayam District. A large proportion have migrated earlier from other parts of Kerala who have settled down converting the forest and mountain slopes into agricultural land. A significantly large proportion of population are Adivasis. The entire region is known for its socio-economic backwardness. Developmental planning is still in its infancy. Basic health care is inaccessible to large sectors. Road transport and communication facilities are still rudimentary. Taking into account the singular features of this region, there is an urgent need to device ways and means to ensure tht the benefits of essential health care reach the poor and the socially disadvantaged communities placed in the remote areas. A community health project is well underway, with provision for a chain of outreach centres and a base hospital at Chelachuvadu (60 bedded). There is imperative need to prepare health auxiliaries, technicall competent and skilled to handle a variety of responsibilities in health care for this region (eg. community/domiciliary nursing, laboratory assistants, physiotherpists/bare-foot counsellors etc. Human resource development forms an important component of the present project.

"the most important role of the village health worker is preventive. But preventive in the fullest sense, in the sense that he help put an end to oppresive inequities, in the sense that he help his people, as individuals and as a community, liberate themselves, not only from outside exploitation and oppressions but from their own short-sightedness, futility and greed".

David Werner

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **EAST KERALA**

Bishop : **Rt.Rev.K.J.Samuel.**

Diocesan Coordinator : **Rev.P.J.Jose.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilita team & place of training.
Annamma Joseph	Kattapana P.O.		
Sherly Sunny	Pallikavala		Rev.Jose Philip Am
Chinnamma John	Kanjiyar		Mr.George Manadadan
Aleyamma John	Ayyappencovil P.O.		Hermon Hospital
Sosamma Abraham	Ayyappencovil P.O.		Parappu,
Leelamma Johnson	Valakodu. P.O.		Kerala.
Raichel George	Upputhara P.O.		
Sherly Ragen	Upputhara P.O.		
Mary John	Chappath.K. P.O.		
Gracy B.Kurien	Chappath.K. P.O.		
Sosamma Chandy	Chappath.K. P.O.		
Thankamma Raju	Chappath.K. P.O.		
Gracy Wilson	Chappath.K. P.O.		

SOUTH KERALA

The Diocese covers two of the most populous district namely, Trivandrum and Quilon. There are extensive tracts falling within this region, known for its socio-economic backwardness all along the foot-hills of western ghats. It may sound paradoxical that hardly 30 - 40 kms south of the capital city, the village communities do not receive essential health care services due to the glaring inadequacies within the 'system'. Though general awareness among people is better and they are conscious of their rights, health care per-se does not seem to have found its rightful place in their own priorities. There are very many small congregations in these remotely placed villages which can really function as change-agents. There are ten hospitals out of which nine are in rural areas. The training of health auxiliaries to meet emerging health challenges in taken on priority. A multipurpose workers training programme for the Kerala region is being established at Karakonam attached to one of the major rural hospitals about 40 kms south of Trivandrum. Responding to emerging challenges - HIV/AIDS, substance abuse, geriatric care etc are items on priority. Plans are underway for evolving a feasible model of comprehensive care for mental health including care of the mentally ill.

...can people who are not trained health professionals contribute to the care of others?

concept is not new. Since the human race began there have always been people who helped with the health problems of others, and even elephants and great apes know how to assist each other to give birth. There have been the shamans, the witch doctors, the wise women, the bone-setters, the herbalists, the traditional birth attendants - and even among the most sophisticated socieities, vestiges of this tradition remain.

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **SOUTH KERALA**

Bishop : **Rt.Rev.Dr.Samuel Amirtham**

Diocesan Coordinator : **Rev.J.Walsalam.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilit team & place of training.
D.Victoria	Periamala	Rev.Z.Samuel	Mr.A.Selwyn Robe
	Neyyatrinkara (Irumbal)		Mr.C.K.Vincent
Ramani		Rev.Jeridass	Prof.Gladis
Rathnabai	Aramada	Rev.Ponnaiyan	Rev.V.P.M.Jeyapau
Baby Valsala	Kattakada	Rev.Kesari	
Jeyachandra Manon-many	Uriakode	Rev.Justus	CSI Hospital Karakonam.
Jeydah Sherley	Vellarda	Rev.Felse	4.11.'91
Sr.Thresamma Josep	Ating	Rev.Manaseh	to
Sheeba	Aramada	Rev.Paulraj	23.11.'91
Shobana	Amburi	Rev.Wilfred	

MADURAI-RAMNAD DIOCESE:

Madurai-Ramnad Diocese is spread in 4 districts (2 are newly constituted). There exists great variation in the state of development among these districts. Ramanathapuram District represents one of the most socio-economically backward regions in the state. Basic health care facilities are inaccessible to large segments of rural population in this region, mainly attributable to inherent weakness in the extant health care system. Recent surveys conducted in the interior villages of Ramanathapuram have revealed a huge burden of morbidity back-log - eg. senile cataract, chronic diseases and disabilities, severe degrees of malnutrition among growing children and adults. The Kilanjunai group of villages is known for endemity of leprosy where the diocesan team is responsible for MDT and follow up. CSI Hospital at Ramnad (St. Martin's) has taken up a rehabilitation programme for polio-affected children has to its credit a splint manufacturing unit. St. Martin's hospital, Ramnad has been able to make remarkable contributions in the field of family welfare planning as part of mother and child care. PPS is a major component of services offered to rural mothers. There is a great need to strengthen the rural outreach programmes. Epidemological investigations too are needed to bring to light the morbidity profile of rural communities with focus on women's health.

Christian Mission Hospital, Madurai is one of the general hospitals of long standing and tradition and has great potentials to be developed as a centre for continuing education and training for various categories of health professionals. Also for evolving feasible models of care to respond the existing and emerging challenges - HIV/AIDS/substance-abuse/terminallj ill. There is a college of nursing attached to the hospital which can be useful resource for evolving meaningful programmes.

Saints wrote and spoke for the masses. The vogue for translating modern thought to the masses in an acceptable manner has not yet quite set in. But it must come in time. I would, therefore, advise young men ..... not to give in but persist in their effort and by their presence make the villages more livable and lovable. Gandhiji

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **MADURAI-RAMNAD**

Bishop : **Rt.Rev.Dr.D.Pothirajulu,B.A.,B.D.,M.A.,Th.D.(Boston).**

Diocesan Coordinator : **Rev.(Mrs.)Ananda Raj.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitator team & place of training.
S.Mercy Vasantha Arputhamani	Uthampalayam	Rev.Gnanaprakasam	Rev. Jacob Dr.Anand Mrs.Susila Backianathan Christian Mission Hospital Madurai 15.9.93 to 5.10.93
S. Mercy Kanagamani P.Velankanni Mary Vasantha Packiam Mercy Jeya Sundari Saroja Elizabeth Rani Joyce Hilda Gnanasundary	Kohilapuram Thathaneri Gopalapuram Arupukotai Puliampatti Shanthinagar Pon Malaipuram Valaseri Ekonilpatti	Rev. Thomas Victor Rev. Christopher Arulraj Rev. Paulraj Rev.Paulraj Rev.Paulraj Rev. Chellapah Rev.Dharmaraj Rev.C.K. Chellapah Rev.John Dorairaj	

TIRUNELVELI

Tirunelveli Diocese is recognised as a missionary diocese with great evangelistic traditions. It has a laudable record of pioneering contributions in the field of rehabilitation, both training and service (blindness, deafness, care of elderly destitutes and the mentally retarded). It has made significant contributions in the field of primary education (has the largest number of primary schools within CSI Dioceses). The diocese has taken the challenge of rural health as an item on priority. Local congregations have made significant contributions in this context. Several rural health care programmes have been started, thanks to the efforts of rural congregations. A multipurpose regional training centre for the Tamilnadu region attached to the CSI Hospital, Nazareth is in the offing. The Diocese has drawn up an innovative programme of a sharing centre for counsellin as a measure towards ensuring mental health taking into account the growing emotional problems among the youth.

..... the prospects for improved standars of living in the poorest and least developed countries are not good in the immediate future. Not only has the gap between rich and poor been widening, but so has the gap between the very poor and the less poor.

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **TIRUNELVELI**

Bishop : **Rt.Rev.Jason Dharmaraj**

Diocesan Coordinator : **Rev.P.Frederick Sathia Samuel.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitat team & place of training.
M. Santha	Thiruchendur	Rev.Gnanaraj Appadurai	Mrs. Victris Grace
Suguna Annapai	Veeramanikam	Rev. Thangadurai	Daniel
Mangalam	Arogyavaram	Rev. Gnanaprakasam	Dr.Jayabalan
Lakshmi	Kalvillai	Rev.P.Pradesick Sathia Samuel	Rev. Simon Sigaman
Vijula Rani	Maninagar	Rev.S. Immanuel Sundersingh	St. Lukes Hospital, Nazareth
Soundirapai	Kadayannodai	Rev. Gnanadurai	21st October'91
Baby Jebarani	Vaithilangapuram	Rev. Sabastin	to
Annamani	Palaniappapuram	Rev. Paulraj	16th Nov'91
Kasturbai	Neivillai	Rev. Veerasingh	
Leelavathi	Oyanagudipost		
Selvamani	Melaseval St		
Agnes	Pannieillai		
Ebenezer Kokila	Nallur		
Bitchi Daisy leela	Sankarancoil		

TRICHY-TANJORE

The territorial jurisdiction extends to Trichinopoly and Tanjore Districts, Dharapuram and Udumalpet, Anamalai Hills falling in Coimbatore District and some parts of Madurai and Pudukottai District. Here again wide variation exists in the state of overall development of the communities in various regions within the Diocese. Dharapuram and scores of villages all around fall within the rain-shadow area known for its low agricultural productivity and poverty and near-famine conditions. Malnutrition is widely rampant. The Dharapuram Hospital and the network of outreach centres catering to the needs of the poor have a major responsibility to evolve patterns of care feasible and sustainable. The college of nursing recently started can be a major potential resource to assist in this process.

The diocese has a large tribal population in the Pachamalai Hills (72 hamlets) where primary health care has hardly made any impact on the lives of people. The diocese has made a beginning in evolving a health care programme linked with development (ensuring inter-council co-operation - CTVT, Education and Healing Ministry). The thrust is to prepare and equip CHGs from among the tribal girls. Woriur is a major general hospital in Trichy town with a school of nursing attached to it. There are several outreach centres under its purview in the peri-urban areas. Karur health centre has a long history of service in the field of leprosy control and rehabilitation. The Karur centre has integrated primary health care with leprosy eradication efforts.

New approaches to the delivery of health care everywhere needed and above all, quicker ways have to be found to help those most in need - the poor, the deprived and the overlooked.....The time left to accomplish this is brief. Knowledge is something which can be shared and ignorance does not imply stupidity.

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **TRICHY - TANJORE.**

Bishop : **Rt.Rev.Dr,R.Paulraj, B.A.,B.D.,S.T.M.(New York)**

Diocesan Coordinator : **Rev.T.Joseph Samuel**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilita team & place of training.
R.Jeyabarathy	Senapathypalayam	Rev. **Simon**	Dr.Ragaviah
Indra	Adhanur	Rev.Jeyakumar Deva	Mr.Sathiaseelan
P.Devakirubai	Devanampalayam	Rev. **Immanuel Rajaiah**	Rev.Joseph Samu
Valarmathi	Kumarapalayam	Rev.Ebenezer	CSI Hospital,
D.Blessy R.Hebshi	Agarmangudi	Rev.Philipraj	Dharapuram
S.Jesumary	Okkanadu Keelaniyur	Rev. **Christopher Chelliah**	11.6.91 to
W.H.Vasanthakumar	Melanatham-P.O	Rev. **M.Samuel**	29.6.91
B.Mariaselvam	**Alakudi**	Rev.Philipraj	
Baby	Pudhu Navakombu	Rev. **Arulraj**	
J.Juliet Margaret	Nangur	Rev.Rajendran	

VELLORE:

A pre-dominently rural diocese covering western parts of South Arcot District and a major portion of North Arcot District and spreading over to Chittoor District of Andhra Pradesh. It is worthy of note that that health care work among the poor rural communities received pride of place among the missionary endeavours in the past. Scudder Memorial Hospital, Ranipet is one of the oldest mission hospitals in the country known for its pioneering leadership, not only in providing 'crisis care' but also for playing a vital role in the control of leprosy and other endemic health problems. The hospital today has extensive programmes to control leprosy and also for the rehabilitation of the disabled and the handicapped (blindness, mental retardation and polio lameness). The diocese has 3 rural hospitals and all of them have extensive involvement and responsibilities in community health care, also in the training of para-professionals and auxiliaries in several fields. The CHG programme adds a further dimension to the diocesan efforts to make primary health care a reality among the village population known for its socio-economic backwardness.

Robert Mugabe, said in 1982:

The problem with the church is that it does not have enough hope. If Christian communities really have faith that we are not left to do this work alon , that God is present in all the struggles of those with goodwill, for transformation, if we believe that the promises will come true that the Kingdom will come, then we could bring to this struggle the greatest imaginable gift, the Gift of Hope.

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **VELLORE**

Bishop : **Rt.Rev.Dr.R.T.Baskeran.**

Diocesan Coordinator : **Rev.Y.John Bhasker**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitat team & place of training.
Kasthuri	Chittoor	Mr.V. Shadrack	Dr.R.A.Manohar Sing
Jeevamani	Chittoor	Mr.V.Shadrack	Mr.Sripatham
Vasantha	Anupalle	Rev.Sampath Sadanan	Mr.Christopher
Prema	Mapatchi	Rev.S.Sadanandam	Mrs.Gladys
Juli	Atmakur	Rev.S.Sathiaraj	Mrs.Amudha
Ruby	Yellapalle	,,	Miss.Gladys
Mary	Mungareddipalle	Mr.V.Shadrack	Ms.Nirmala
Snamala	M.Krishnapuram	Rev.Barnabas	Mr.Nagimaidoss
Meena	Thodathara	Rev.D.Cornelius	Mr.Titus Rajakumar
Malliga	Muttathur	Rev.O.Rajendra prasad	CSI Jothinilayam Rural Hospital, Muttathur 1.11.91 to 30.11.91

NORTH KARNATAKA

Karnataka Northern Diocese covers districts of Northern Karnataka, Bellary, Simoga, Chitradurga and Challakere This is yet another predominantly rural diocese known for socio-economic backwardness. Diseases of poverty and deprivation eg. TB, malnutrition are very common especially among the socially disadvantaged communities in the Bellary region. A community development programame with provision for meeting essential health care using local resources, maximally has been in operation for several years. Women volunteers from the same communities including local dais were given orientation training and successfully engaged. Specific responsibilities entrusted to them included monitoring of growth and development of children, care during pregnancy, follow-up of TB patients. There is a general hospital at Gadag-Betgeri which provides care at secondary level. The rural health centre at Motebennur has been revived and serves a group of remotely placed villages. It has been directly responsible for the training of CHGs. Several of the CHGs are drawn from among the Adivasis and some of the traditional dais who are given training in basic health care. There is great need for extending care to many more regions. Plans are underway for reviving the Guledgudd hospital as a rural health centre which would be able to supplement health care facilities in about 100 outlying villages. The region is also known for its endemicity for leprosy.

"Health care will only become equitable when the skills pyramid has been tipped on its side, so that the primary health worker takes the lead and so that the doctor is on tap and not on top."

David Werner

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **KARNATAKA NORTH.**

Bishop : **Rt.Rev.Vasant P.Dandin.**

Diocesan Coordinator : **Mr.G.C.Tallur**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/Facilitat team & place of training.
C.S.Akki B.S.Badiger G.D.Katenahalli S.N.Savantwadi V.P.Chindwal G.G.Mastanniyovar S.G.Baratakke M.T.Balgar H.M.Talwar K.N.Lamani	Budapanahalli Kengonda Arabagonda Motebennur Guruvinahalli Alalageri Kanavalli Kalledevav Kadamanahalli Kalladevar Tanda		Dr.Jeyalakshmi Thiagaraj, Rev.S.J.Nadugaddi CSI Community Health Centre, Motebennur 22.9.'91 to 12.10.'91

SOUTH KARNATAKA

South Karnataka Diocese covers an extensive area covering, South Kanara, Coorg, Chikmagalur, Hassan, Mandya and Mysore Districts and Talavadi area inCoimbatore District of Tamilnadu. There are 3 main hospitals which are engaged in outreach work in remote villages. Training of nurses, auxiliaries and para professionals is carried out in the 3 hospitals at Mysore, Hassan and Udupi. Basic health care facilities are not available to a large number of outlying villages, especially falling within the erstwhile Mysore state. Rural health centre at Mangala has been revived recently and can play a significant role in the context of primary health care. There are large segments of rural population in and around Hassan where there is great need for supplementing primary health care activities. There is an on-going programme of rural development and health which is highly relevant, and needs to be strengthened. CHGs have a key role to play especially to create health awareness among the village communities.

"The whole life of Jesus was a struggle against this injustice and this was experienced by him in a deep identification with the poor. 'The foxes have holes, and the birds of the air have their nests, but the Son of Man has not any place to lay down his head'.

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **KARNATAKA SOUTH**

Bishop : **Rt.Rev.D.P.Shettian, M.A.,B.D.**

Diocesan Coordinator : **Mr.Reginold C.Soans.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitat team & place of training.
Suvarnalatha	Madapura, Chamrajanagar Tk.	Rev.Osmand N.Shri	Mrs.Ileen P.Karked Mr. A.Prabhuchand
Geetha	Bhogapura, Ch.Nagar Tk.	Rev.M.Vasantha Kumar	
Lilly Sugandaraj	Hosakoppaly, Hassan Dt.	Rev.Sudheer Prakash	Lombard Memo-rial Hospital, Udipi.
Premaleela Rani	Hosakoppaly, Hassan Dt.	Rev.Sudheer Prakash	20th Sep.'91 to 20th Oct.'91
Prema P.Karkada	Mulki, Mangalore Tk.	Rev.D.A.Satwata	
Usha Prabhavathi	Manipura, Udupi Tk.	Rev.Gladson D. Ananda	

CENTRAL KARNATAKA:

Central Karnataka diocese covers Bangalore city and civil district, Tumkur and Kolar. It remains a paradox that the large segment of rural population in the erstwhile Mysore state have been denied basic social amenities including health care during the past. Inspite of policy pronouncements to the contrary, there are gross inadequacies in the existing health system in that the health care needs of rural population remain almost unmet. The voluntary sector have a critical role to create health awareness among people about the 'needs' as also about the available facilities and their fuller utilisation. It is here that CHGs have a critical role to play. The diocese has a major hospital in Bangalore, which also trains nurses and para-professionals. The hospital today is engaged in an effort to evolve feasible models of care responding to emerging challenges - care of the elder citizens, terminally ill, HIV/AIDS. Chickballapur is a general hospital catering to the health care needs of population. in a large number of outlying villages.
It has a school of nursing, also taking part in rural outreach programmes. The diocese has rural hospital at Chennapatna which has a long tradition of service to the rural community, especially women. The special significance is that a large segment of the local community are muslims and essential care reaches Muslim families.

But health care is after all, about <u>people</u>. It maybe that people can make much more of a contribution to their own health than has up till now been brought within our reckoning of the world's health resources. If imagination and ingenuity can be exercised by the health professionals, there maybe alternative ways to bridge the gaps.

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **CENTRAL KARNATAKA**

Bishop :

Diocesan Coordinator: **Dr.V.Hymavathi/Rev.F.S.Macwana.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitat team & place of training.
J.Jasmin Sasikala	K.G.F.		
R.Purna Kanthi	K.G.F.		Dr.(Mrs)V.Hymavath
G.Prameela	K.G.F.		Mrs.Annamma Manoha
Beula	Tumkur		Mrs.H.Blessing
Sujatha	Tumkur		CSI Hospital Bangalore
Fathima	Tumkur		29th Sep. '92 to 21st Oct. '92
Neelam Ekka	Bangalore		

COIMBATORE

Coimbatore diocese covers an extensive area covering Nilgiris, Salem, Periyar and Dharmapuri District. Almost one third of Coimbatore diocese comprises of mountains and hills with congregations in tea and coffee plantations and tribal villages. Krishnagiri District is declared as the most backward District. Extremes characterise the state of socio-economic development of communities within the region. Erode town and neighbouring villages are known world over for the high quality of handloom products. The weavers however, are extremely poor and highly exploited, exposed to occupational hazards -dyes, dust and working conditions. The large Adivasi population inhabiting the mountain ranges reveal ethnic diversity and cultural singularities. Essential health care needs of the rural population particularly in the remote hilly tracts are mostly unmet. Standards of housing and sanitation are deplorably low. Ecological degradation arising from wanton destruction of trees in the high ranges adds a new dimension in development planning. The diocese has taken a leadership role in responding to the emerging challenges. Building community capability in health and development appear to be extremely relevant for the communities under reference. There is a major hospital in Erode, which has also a training wing for preparing nurses and auxiliaries and also a chain of rural health centres. The one in Marandahalli in one of the most interior villages focuses on programme for prevention of blindness as part of primary health care.

I have the audacity to believe that peoples everywhere can have three meals a day for their bodies, education and culture for their minds, and dignity equality and freedom for their spirit. I believe that what self-centred men have torn down, other centred people can build up. I still believe that one day humanity will bow before the altars of God and be crowned triumphant over war and bloodshed, and non-violent redemptive goodwill will proclaim the rule over the land. And the lion and the lamb shall lie down together and every man shall sit under his own vine and fig tree and none shall be afraid. I still believe that we shall overcome.

Martin Luther King

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **COIMBATORE**

Bishop : **Rt.Rev.William Moses, B.A.,B.T.,B.D.,S.T.M.**

Diocesan Coordinator : **Rev.D.V.Karunakaran**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitato team & place of training.
Josphenal Mary	Perukkalinji	Rev.D.V.Karunakaran	Mrs.Saraswathi Nehru
Pappathy/Alice	Samathanapuram	Rev.D.V.Karunakaran	Mrs.Marina Stewett
VasanthaKumari	Thiruvatchi	Rev.D.V.Karunakaran	CSI Hospital
Suganthi Mary	Kavandapadi	Rev.Natheniel/Jeyaraj	Erode.
Jeyaseeli	Veerachipalayam	Rev.D.V.Karunakaran	7.6.'91
Thilagavathi	Grey Nagar	Rev.D.V.Karunakaran	to
Ratinammal	Brough Nagar	Rev.Natheniel/Jeyaraj	6.7.'91
	Senapathipalayam	Rev.Maduram James Chelliah	
J.Vani	Kanjikovil	Rev.D.V.Karunakaran	
Kalarani	Ingur	Rev.Maduram James Chelliah	
Selvakumari			

KANYAKUMARI

The smallest diocese and the southern most within CSI. Kanyakumari Diocese has to its credit a network of major hospitals and a chain of health care institutions with a laudable record of service spanning more than one and a half centuries. Neyyoor Hospital and the International Cancer Centre have their credit has well laudable record of service spanning a period of over 1½ centuries. ICC is the only centre within the CSI network providing care for cancer patients. Plans are underway for introducing cancer screening for early detection, utilising the peripheral rural health network within CSI utilising the available health manpower including the CHGs. Kanyakumari Diocese has a major community health care project with a rural hospital and five outreach centres, catering mostly to the rural poor in the foot-hills including a large sector of plantation labour. There are many interior villages where primary health care facilities have yet to reach. Hence the great contextual relevance of the Community Health Guide programme.

Hope for a Better World

It is time we stopped talking of despair
and started living in hope.
It is time that we started reading and hearing
more
of the good that people can do for themselves
and for others.

IMPLEMENTATION OF HEALING MINISTRY COMPONENT OF VELCOM - COMMUNITY HEALTH GUIDES PROGRAMME.

(EZE PROJECT NO: 86096/90082)

Diocese : **KANYAKUMARI**

Bishop : **Rt.Rev.G.Christdhas, M.A.,B.D.**

Diocesan Coordinator : **Rev.P.J.Jeyaseelan.**

Names of CHG's	Villages/hamlets under care	Names of Church leaders	Trainer/facilitato team & place of training.
R.Selvi P.Selvi J.Gnana Goldah R.Devika	Jamestown Dennispuram Chanthayadi Kakanputhur	Rev.D.Rethna Raj Mr.Appathurai Mr.Yesu vadian Mr.P.Gnaniah	Rev.P.J.Jeyaseela Mrs.Matilda Jeya- kumar CSI Hospital Neyyoor 22.8.'91 to 22.9.'91
B,Catherine Baby V.Little Sulojana T.Nesam S.Kujala	Pallikal Arumanai Vazavilai Idenipuram	Rev.Chellakan Mr.P.Rose Mr. Rajaiah Rev. Masillamani	

MADRAS:

The diocese is recognised nationally and internationally for its pioneering contributions in the field of human resources development achieved mainly through educational institutions. It has also contributed in a significant measure to health care through its institutional ministry, urban, suburban and rural hospitals during a period covering almost in 2 centuries. The major hospitals are also engaged in the training of nurses, auxiliaries and para-professionals. The diocese covers a large rural population. There are encouraging developments in recent times, where the diocese has taken bold steps to initiate meaningful programmes for the benefit of the rural poor, espeically, the socially disadvantaged communities. The diocese is today engaged in a major effort to give a positive thrust to rural development. The role of the Community Health Guides is seen from this perspective.

The target set is to set a community health guide for every major village inhabited by the poor and the marginalised communities. It is encouraging that 50 CHGs have been trained and positioned in the peripheral rural areas as of date.

Ultimately, the vision the Christian has is the vision of the Kingdom that Christ came to establish.

"The Kingdom of God undoubtedly possessed a political connotation for the Jews; for whome politics was a part of religion, and the Kingdom of God concretely designed liberation from all oppressive forces.

COMMUNITY HEALTH GUIDE
ON HER ROUTINE VISIT TO THE VILLAGE

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